thewellness Institute

Pre-Participation Screening

Welcome to the Wellness Institute. You are joining a medically integrated health and fitness center that caters to all age groups and abilities and is part of healthcare's continuum of care.

As a medical wellness/fitness center, our member's health is a priority and we have an enrolment process that is more thorough than your typical fitness center.

The joining process begins with a **pre-participation screening questionnaire** identifying your health risks, injuries and medical concerns. This information helps us determine the most appropriate type of assessment we can offer you to develop a safe and effective exercise plan.

Consent to Participate

Please carefully read the following Consent to Participate. Once you have read the Consent, please **initial each of the statements to which you agree and leave blank any statement to which you do not agree.** Finally, sign and date the form at the bottom where indicated.

I, ___________________________________ , (print name), hereby consent to participate in the Health Risk Assessment Screening that will indicate my qualification for a health & fitness assessment, physiotherapy health & fitness assessment and/or the requirement for medical clearance. I understand that personal health information collected about me will be used to assist the Wellness Institute in developing an individualized exercise plan and to evaluate the Wellness Institute's membership programs. I understand that the information about me will be collected, stored, and destroyed in compliance with The Personal Health Information Act of Manitoba (PHIA). If I have any questions or concerns about the collection, storage, or destruction of my personal health information, I understand that I may direct them to the Seven Oaks General Hospital PHIA Officer at (204) 632-3288.

Personal health information will be collected for research, quality improvement and evaluation initiatives. This information will be collected, linked with other datasets, and stored per the privacy and data collection laws. All data access requests and linkages must be reviewed and approved by the Seven Oaks Hospital Research Director and appropriate review boards. Only aggregated, de-identified data will be presented in research or evaluation reports.

1. I have read and understood the above Consent and **agree** to participate in the Health Risk Assessment Screening. ____________ (Initial)
2. I **agree** to have the Seven Oaks General Hospital Wellness Institute contact me regarding follow-up and evaluation.____________ (Initial)

Name: ______________________ **Member #:** ______________________________

Date: ______________________ **Member Signature:** ______________________

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Pre-Participation Screening Questionnaire

First Name: ______________________ Last Name: ______________________

Date of Birth: ______________________ PHIN (9-digit): ______________________

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex

(we require this for different tests we may complete with you).

Emergency Contact Information

Name: ____

Relationship: ______________________ Phone Number: ______________________

Physician Contact Information

Physician Name: ____

Clinic Name: ______________________ Phone Number: ______________________

Part 1 – Please check all that apply:

A) Are you currently experiencing any of the following symptoms?

- ☐ Chest discomfort with or without exertion
- ☐ **Unreasonable** breathlessness
- ☐ Dizziness, fainting or blackouts
- ☐ Ankle swelling
- ☐ Unpleasant awareness of a forceful, rapid or irregular heart rate
- ☐ Burning or cramping sensation in your lower legs when walking short distances

B) Have you been diagnosed with Cardiac, Metabolic or Renal Medical Conditions such as:

- ☐ Cardiovascular disease *(i.e. heart attack, stent, angina)*
- ☐ Other heart condition *(i.e. heart surgery, valve disease, heart failure, heart transplant, arrythmia, pacemaker/defibrillator, congenital heart disease)*
- ☐ Peripheral Artery Disease
- ☐ Diabetes
- ☐ Kidney Disease

C) Have you participated in at least 30 minutes of moderate intensity physical activity, on a minimum of 3 days per week for the last 3 months?

(Moderate activities include walking, active gardening, swimming, dancing, biking, etc. and result in a noticeable increase in breathing and heart rate). ☐ Yes ☐ No

Part 2 – Do you have any of the following other health conditions?

- ☐ Lung condition that **significantly** impacts your ability to exercise *(please specify):* ____________________
- ☐ Use of supplemental oxygen/oxygen tank
- ☐ Osteoporosis
- ☐ Balance challenges or falls
- ☐ Rheumatoid condition *(please specify):* ____________________
- ☐ Stroke
- ☐ Spinal Cord injury
- ☐ Neurological condition *(i.e. Parkinson's, Fibromyalgia, Multiple Sclerosis, seizures, etc.):*
- ☐ Cancer, diagnoses < 12months ago
- ☐ Muscle or joint pain **significantly** limiting your physical activity *(please specify):* ____________________
- ☐ Recent joint replacement *(within the past 12 months):* ____________________

Part 3 – Please check all that apply:

- ☐ Smoked in the past 6 months *(includes vaping)*
- ☐ Male >45 years old or female over 55 years old
- ☐ Diagnosis of high blood pressure or are being treated for high blood pressure
- ☐ Diagnosis of high cholesterol or are being treated for high cholesterol
- ☐ Were any of your blood relatives diagnosed with heart disease or stroke before the age of 55 (male) or 65 *(female)*
- ☐ Living with pre-diabetes *(high levels of blood sugar but not diagnosed with Diabetes)*

Part 4: Please list all medications you are currently taking:

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